

**COUNTY OF SAN LUIS OBISPO BOARD OF SUPERVISORS  
AGENDA ITEM TRANSMITTAL**

|   |   |   |                     |
|---|---|---|---------------------|
| (1) DEPARTMENT<br>Behavioral Health   | (2) MEETING DATE<br>3/17/2015               | (3) CONTACT/PHONE<br>Anne Robin, LMFT, 781-4719   |                     |
| (4) SUBJECT<br>Report from the Health Agency/Behavioral Health Department on the Department's current service delivery system. All Districts.   |   |   |                     |
| (5) RECOMMENDED ACTION<br>It is recommended that the Board receive and file a report and presentation on the Health Agency/Behavioral Health Department's current services delivery system. |   |   |                     |
| (6) FUNDING SOURCE(S)<br>N/A  | (7) CURRENT YEAR FINANCIAL IMPACT<br>\$0.00 | (8) ANNUAL FINANCIAL IMPACT<br>\$0.00   | (9) BUDGETED?<br>No |
| (10) AGENDA PLACEMENT<br>{ } Consent    { <b>X</b> } Presentation                      { } Hearing (Time Est. ____ )    { } Board Business (Time Est. ____)                                 |   |   |                     |
| (11) EXECUTED DOCUMENTS<br>{ } Resolutions    { } Contracts    { } Ordinances    { <b>X</b> } N/A   |   |   |                     |
| (12) OUTLINE AGREEMENT REQUISITION NUMBER (OAR)<br>N/A  |   | (13) BUDGET ADJUSTMENT REQUIRED?<br>BAR ID Number: N/A<br>{ } 4/5 Vote Required        { <b>X</b> } N/A |                     |
| (14) LOCATION MAP<br>N/A  | (15) BUSINESS IMPACT STATEMENT?<br>No       | (16) AGENDA ITEM HISTORY<br>{ <b>X</b> } N/A    Date: _____   |                     |
| (17) ADMINISTRATIVE OFFICE REVIEW<br>Reviewed by Leslie Brown   |   |   |                     |
| (18) SUPERVISOR DISTRICT(S)<br>All Districts  |   |   |                     |

# County of San Luis Obispo



TO: Board of Supervisors

FROM: Anne Robin, LMFT, 781-4719

DATE: 3/17/2015

SUBJECT: Report from the Health Agency/Behavioral Health Department on the Department's current service delivery system. All Districts.

## **RECOMMENDATION**

It is recommended that the Board receive and file a report and presentation on the Health Agency/Behavioral Health Department's current services delivery system.

## **DISCUSSION**

### **Introduction/Background**

Mental and substance use disorders affect people from all walks of life and all age groups. These illnesses are common, recurrent, and often serious, but they are treatable and many people do recover.

Mental illness and substance use disorders are increasingly a topic of significant community interest. That is due primarily to the following factors: 1) the increased attention to mental illness and substance use disorder in the media, the community, and through focused educational efforts to increase acceptance of treatment and reduce stigma; 2) the dramatic changes to the health care delivery system brought about by the Affordable Care Act (increased Medi-Cal enrollments; coverage for mild to moderate mental illness; and expanded scope of benefits for Drug Medi-Cal) and 3) the role mental illness and substance use disorders play in such important topics as violent crime, jail and prison population management, and homelessness.

Increased community interest often brings increased attention, scrutiny, and service delivery expectations, prompting the Board of Supervisors to inquire about whether the County's behavioral health care services delivery system is doing all it should, doing the right things, operating efficiently and effectively, etc. Those questions have prompted an assessment of the system, and produced the observations contained in this report.

### **Mission and Mandate**

The public behavioral health care system, which in California is contracted to each of the 58 counties through contracts with the State Department of Health Care Services (DHCS), have specific mandates, funding, and eligibility requirements. Proposition 63, the Mental Health Services Act (MHSA), expanded the range of services for mental health services to include prevention, intensive services, innovative services studies, system development, housing, and capitol facilities/information technology upgrades. Prior to 2004, when the voters passed Prop 63, the mental health system relied solely on funding from state sales tax and vehicle license fees (1991 Realignment) matched with Federal Medicaid dollars. The substance use disorder field, (referred to as Drug and Alcohol Services, or DAS, in San Luis Obispo County) similarly receives State dollars to match with Federal Medicaid dollars, as well as grants and other federal funds.

In 2011, a "new" Realignment changed the funding system to merge the "behavioral health sub-account" into a locally available "pot" of funding from sales tax to utilize as the "local match" for federal Medicaid dollars.

The SLO County Behavioral Health Department (hereafter "the Department"), which provides the specialty mental health services to the Medi-Cal and indigent population in the county, is considered a "mental health plan", or managed care

entity. The target population for the approved services is comprised of individuals who suffer from serious emotional disabilities (children and youth) and severe mental illness (adults). Eligibility for services are further limited to specific diagnoses, with a required “functional impairment” level, or inability to perform daily life skills and social/educational/vocational activities due to the symptoms of mental illness. (Attachment 1)

Substance Use Disorder services, or Drug and Alcohol Services (DAS), are similarly controlled by the contract the County holds with DHCS. Individuals must have a medically indicated diagnosis of addiction, are primarily served in a group format, and may either be served in a court diversion program or in a “voluntary” program. Additional specialty programs, such as the Veteran’s court, Behavioral Health Treatment Court, and increased Drug Court services are funded by grants and/or county general fund dollars.

Other services provided by the Department include prevention and outreach services, which are primarily funded through Federal SAPT (Substance Abuse, Prevention and Treatment) dollars, and MHSA funds. MHSA has a strict set of rules for program development and operations with local stakeholder input. For more information about the Department’s MHSA programs, please see the MHSA plans at [www.behavioralhealth.com](http://www.behavioralhealth.com). A brief summary of MHSA programs is included in Attachment 2.

Services which are not mandated by the State, and which have not typically received funding, include housing, “detox”, case management for substance use disorder clients, sobering centers, and services for mild to moderate impairment due to a mental health diagnosis. These are some of the most frequently mentioned “gaps” by community and partner agency stakeholders.

With the Affordable Care Act, a new group of Californians are now eligible for Medi-Cal. These individuals comprise single adults who have not been certified as disabled under the Federal Social Security Act, and whose income is at or below 133% of the Federal Poverty Level. Many of the individuals who have sought behavioral health services in the past include individuals who meet these criteria. New benefits include access to psychotherapy and psychiatric services for individuals who have mild to moderate levels of mental health needs, and expanded services for substance use disorder treatment. CenCal Health, the managed care plan entity for Medi-Cal in San Luis Obispo and Santa Barbara Counties, is responsible for developing the network of providers to meet the needs of individuals with mild to moderate impairment due to a mental illness. The Department is currently the primary provider of Drug Medi-Cal eligible services in the County. The Department manages a contract with Aegis Corporation in Atascadero to provide a Narcotic Treatment Program which provides medically assisted withdrawal treatment (Methadone) and counseling for opiate addictions.

### **Oversight**

The programs the Department administers for the County are monitored by a combination of State, Federal, and local audits and reviews.

DHCS audits the drug and alcohol programs for compliance with the current state contract, including policies and procedures, services, documentation, privacy concerns, fiscal controls, and other areas. These are done as follows:

- State-County Performance Monitoring Review (annually)
- Program Certification Audits (bi-annually)
- Independent Peer Review Audit (bi-annually)
- DUI Audits (bi-annually)

Grants from SAMHSA (Substance Abuse Mental Health Services Agency) and other funders are required to have annual site visits for progress and compliance monitoring.

DHCS also performs a triennial Medi-Cal audit for Mental Health services. This is an intensive review of policies and procedures, documentation, services, fiscal controls, and compliance with a host of requirements laid out in the state contract applicable to those programs. DHCS is also responsible for certification of all the sites at which Medi-Cal services are provided, both Drug Medi-Cal and Mental Health. The Mental Health Divisions also have an annual “External Quality Review Organization” (EQRO) survey which focuses on multiple service delivery elements.

The Psychiatric Health Facility (PHF) is licensed by DHCS. As a part of their licensing program, DHCS conducts an annual unscheduled licensing survey and site visit. Monthly internal medication monitoring and quality services meetings include a range of professional staff and stakeholders. Updated by-laws for the PHF were approved by your Board in 2014, and include the formation of an Executive committee, which will meet at least semi-annually to review the PHF’s

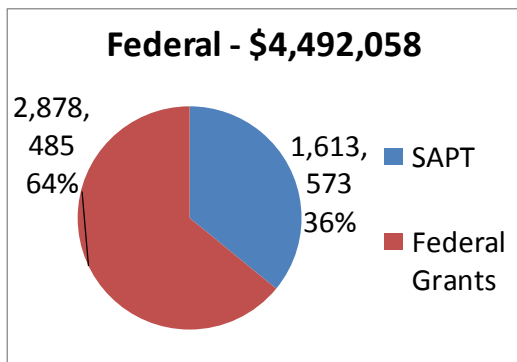
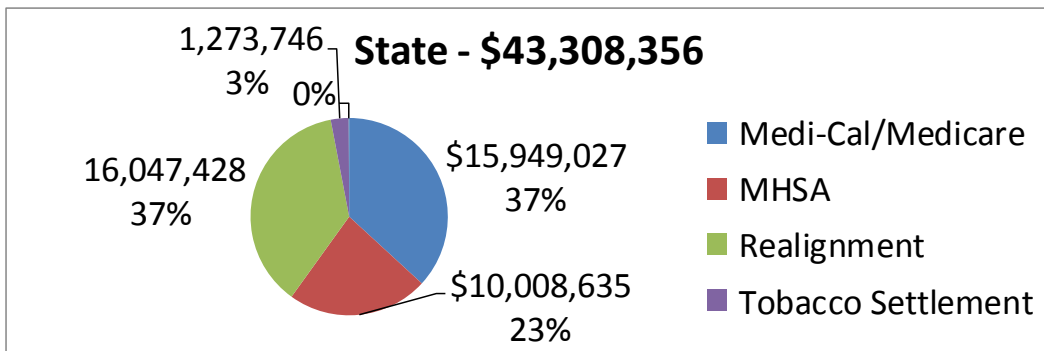
performance and challenges.

Internal reviews and surveys are completed by treatment authorization reviews, reviews of ongoing services documentation, peer review of medical services and documentation. Annual site certification visits of all contractors, utilization reviews, and quarterly contract monitoring ensure that quality services are also provided by agencies performing services on behalf of the County, through contracts administered by the Department.

### General Funding Information

The programs operated and contracted by the Department are funded through various local, State, Federal, and grant funds. Each set of funding has specific criteria for eligibility, service level, compliance, and interventions.

The following charts show the percentages of State and Federal financing for the Department. 88% of the Department's funding is from non-local sources. A summary of mental health finance sources is included in Attachment 3 & 13. Drug and Alcohol funding is more limited, with funding available only through State 2011 Realignment funds, Medi-Cal, fees for services, local funds, and grants.

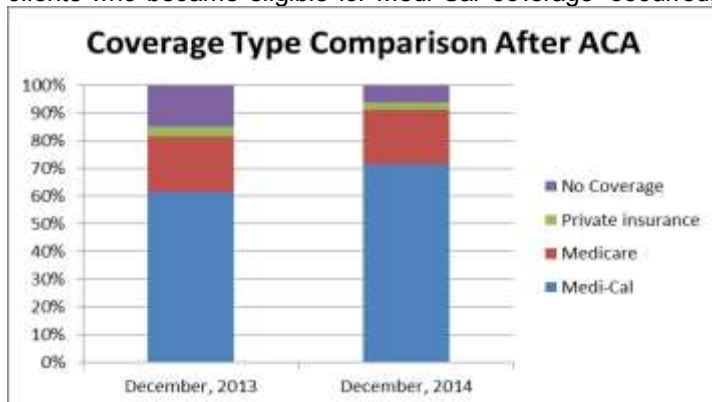


**Revenue Sources**

|                      |                       |       |
|----------------------|-----------------------|-------|
| Fines/Fees           | - \$3,714,456         | • 6%  |
| State                | - \$43,308,336        | • 74% |
| Federal              | - \$4,492,058         | • 8%  |
| General Fund Support | - \$7,288,994         | • 12% |
| <b>Total</b>         | <b>- \$58,807,671</b> |       |

### Capacity and Service Delivery Levels

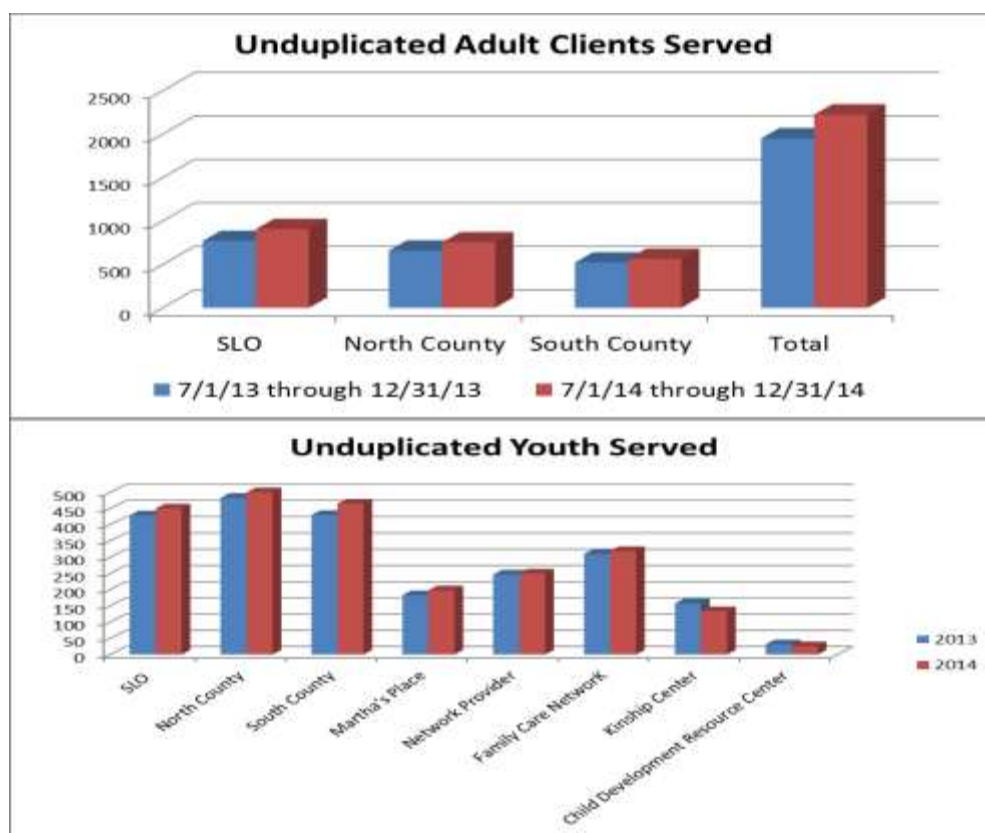
Several trends have been noted as a result of the Affordable Care Act. An expected shift from “unsponsored” clients to clients who became eligible for Medi-Cal coverage occurred, with a peak mid-year in new enrollments for Medi-Cal.



A mid-year peak for requests for services was also noted, with a traditional downward trend during the holiday season.



The number of adults served in the Mental Health Division increased by 14% over the previous year, and by 5.8% for youth.



### System Assessment (External Perspective)

Following the resignation of her predecessor (to take a position with the State Department of Health Care Services), the County hired the current BH Administrator in late December 2013. Throughout calendar 2014 she met with many community stakeholders to gather information, gain from their perspectives, etc. The list of those stakeholders includes, but is not limited to, representatives from the Sheriff's Office, the Superior Court, the Public Defender, the District Attorney's Office, the Department of Social Services, School Districts, and a wide range of community based organizations such as the hospitals and other health care organizations, the local chapter of the National Alliance on Mental Illness (NAMI), the Behavioral Health Board, homeless services providers, family members, and consumers.

At this point in time, following that stakeholder driven information gathering process, the following service delivery gaps or service level deficiencies have been identified. For each gap or deficiency identified, staff will attempt to identify the reason for the deficiency and a course of action that would be required to mitigate the deficiency.

### Access

Timely access to services has been identified by all groups as problematic.

The wait time for adult mental health assessments has varied from 11 to 54 days, far beyond the State recommended standard of 14 days. Youth wait times for mental health assessment have been somewhat closer to standard, from 7 days to a maximum of 41 days. Assessments may only be completed by Masters' or higher level licensed clinical staff.

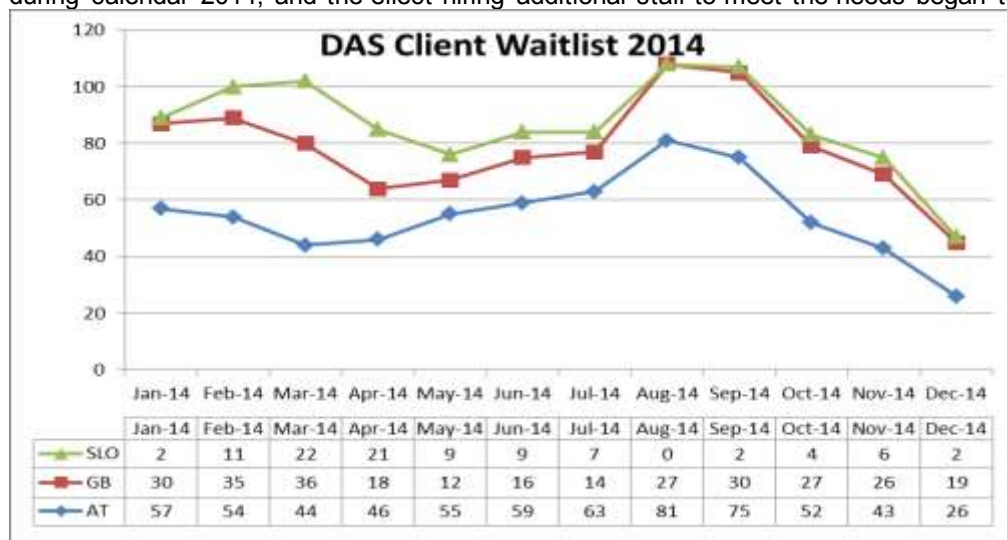
The Department has had a deficit of licensed clinicians in adult mental health outpatient services. The recent downturn in the economy which prompted cuts to core services shifted some clinical staff from the general outpatient services to MHSA funded programs. Core services are those which are mandated in W&I Code 5600 and contracted with the State. They include assessment, medication services, case management, psychotherapy, rehabilitative services, treatment planning, and crisis services. The proposed solution to this particular concern is to request additional clinical staff in Adult outpatient services. Youth mental health staffing has typically included more licensed clinicians; however, as requests for services and specialty program needs increase, additional Youth services staff will be needed. The Department has submitted budget augmentation requests for both adult and youth clinician positions to meet these needs.

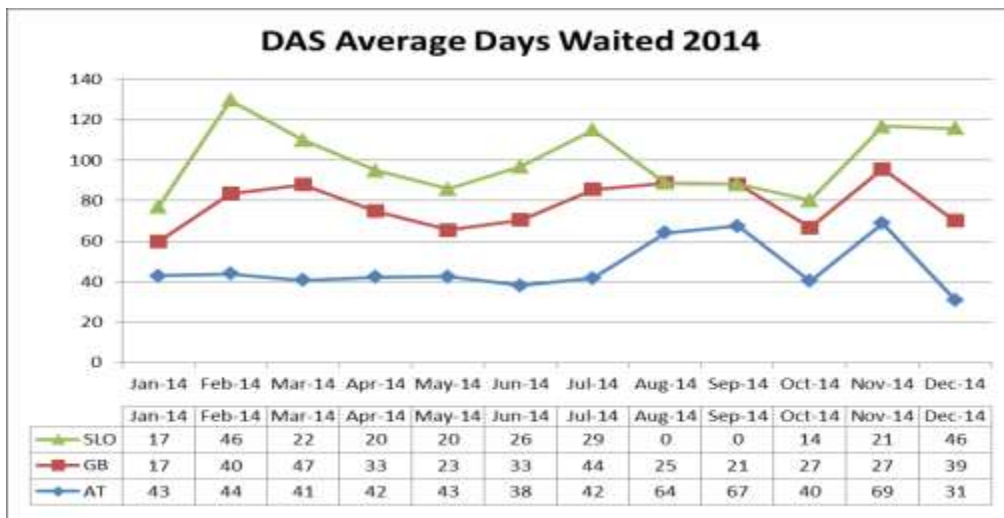
Drug and Alcohol Services has also seen increase in wait times for entry into treatment. The increased number of newly eligible Medi-Cal beneficiaries and the expanded scope of Drug Medi-Cal benefits have substantially increased demand for services. While fourteen new positions were included in the adopted 2014/15 budget, a number of uncontrollable factors have contributed to it taking longer ramp up treatment capacity that was anticipated. The positions are now filled, and we are seeing steady reductions in wait times.

Several groups have preferential access to treatment, including parents referred by Child Welfare Services, intravenous (IV) heroin users, and pregnant/perinatal women. As both eligibility and coverage for services expand, the Department is responding by shifting resources to cover groups whenever possible. Additional staff to cover drug testing and services in North County are being requested in the 2015/16 budget as reflected budget augmentation requests submitted by the Department.

The standard for intake into Drug and Alcohol services is different than for Mental Health. A screening is required upon request. The more extensive assessment and entry into treatment must occur within 30 days, with the exception of CalWORKs referrals, IV Heroin users, and pregnant women who must receive interim services immediately after screening.

The following charts represent the number of clients who were on a wait list by month, the wait times in days experienced during calendar 2014, and the effect hiring additional staff to meet the needs began to show toward the end of the year.





### Crisis Response

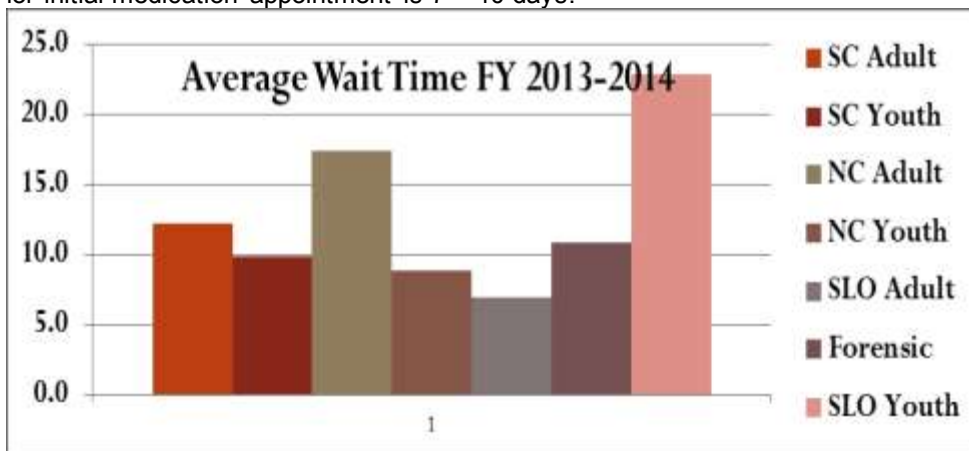
Law enforcement agencies and hospitals have both appreciated and critiqued the level of mobile crisis response service provided by the Department. Over 1600 responses were provided during 2013/14. Partner agencies have mentioned increased requests for services, need for additional support at the hospital emergency departments, inability of law enforcement agencies in both the far North and South of the county to wait for mobile crisis responders, and inconsistent responses to calls for service.

The Department has historically contracted with a provider, SLO Mobile Crisis Services, to meet its crisis response obligations. In 2014/15, the Department received approval to enhance its crisis response capability by adding three in-house positions to work in conjunction with our contractor. The positions were funded with a combination of state grant and MHSA funds.

### Treatment

Consistent, available psychiatrist service has been identified as a primary concern by family members, clients, and agencies involved with our clients.

The chart below shows the wait time for first appointment with a psychiatrist after initial clinical assessment. The standard for initial medication appointment is 7 – 10 days.



Another concern has been the constant changing of medical providers. As the Department has had difficulty in recruiting full time Staff Psychiatrists, we have utilized "Locum Tenens" companies which make temporary placements of psychiatrists. Some providers have only had short term placements in our sites. Each provider has their own style of practice, and medication changes may occur from provider to provider.

In an attempt to address the Department's recruitment and retention problem with staff psychiatrists, in 2014 your Board approved a substantial increase in compensation for psychiatrists. While this has increased interest in the positions, it has not yet accomplished the intended outcome. There continues to be a State-wide paucity of available psychiatrists interested in working within the county behavioral health systems. Staff believes that is because the pay rate for psychiatrists employed by the State at either Atascadero State Hospital or the California Men's Colony still surpasses the County's improved salary and benefit package. Several proposed solutions will be covered in the Internal Gap analysis section below.

### **Geographically Available Treatment**

Since the closure of the Paso Robles mental health clinic five years ago (a budget cut made in 2009-10), clients and families have mentioned many times that transportation to the remaining North County clinic in Atascadero is difficult and provides a barrier to access.

The Department has opened a small clinic for Drug and Alcohol services in Paso Robles, and plans to expand and add mental health services on a minimal basis to that site. The Department has requested additional support for Paso Robles services through 2 budget augmentation requests which include funding for space, administrative support, and clinical staff.

South County has also seen a growing need for services. The Mental Health clinic site in Arroyo Grande has one supervisor for all adult and youth services. There is only one licensed clinician, other than the Program Supervisor, to provide clinical services to adults in that location. The reason for insufficient clinical staff, as discussed previously, is a result of the economic downturn and subsequent cuts to core programming. The Department has submitted a budget augmentation request for funding of an additional Program Supervisor and 2 licensed clinicians in South County. These positions will enhance the quality and quantity of available treatment, increase oversight capacity, and decrease wait times for access to services.

### **School Based Treatment**

Several school districts have requested additional treatment services on school campuses for both mental health and substance use disorders.

Funding for non-medically necessary services on school campuses has been provided to the school districts through contracts. Medically necessary services, or those covered by Medi-Cal, may also be expanded to new school sites in the coming year. Additionally, Educationally Required Mental Health Services (ERMHS) are covered in part through Medi-Cal funding and through school funds, and are provided on many school campuses in the County.

Prevention services have long been successfully provided on many school campuses. These are funded through SAPT dollars, MHSA, and local sources.

The Department is working closely with schools to contract for additional substance use disorder treatment services, and will continue to work with schools for additional mental health treatment. Both of these initiatives may require additional clinical staffing, and the Department has submitted budget augmentation requests for staffing school based substance use treatment and mental health treatment.

### **Access to Psychiatric Inpatient Services**

The 16 bed Psychiatric Health Facility (PHF) run by the Department comprises the only psychiatric inpatient services in the County. On average, the Department sends 350 individuals to out of county facilities for inpatient care each year. Families, clients, and other stakeholders have frequently been concerned both about the amount of time it takes to facilitate placements to out of county hospitals as well as the difficulty for families to engage in treatment with their loved ones while in these hospitals. Children are sent as far as Santa Rose for inpatient treatment, and seniors have been sent as far as Newport Beach. Hospital emergency departments report seeing up to five psychiatrically involved patients daily. An additional local psychiatric inpatient facility (or facilities) would also reduce the impact on both law enforcement and the hospital emergency rooms for disposition of individuals in psychiatric crisis.

Several proposed developments are in process. A 96-bed psychiatric hospital in Templeton has been proposed by a private landowner and developer (see Attachment 4). Marian Regional Medical Center in Santa Maria is also proposing to establish a 26 bed General Acute Hospital Psychiatric Unit, which could accept medically fragile adults and seniors.

### **Hospital Alternatives**

A Crisis Stabilization Unit (CSU), which can accept individuals in psychiatric crisis for up to 23 hours, would be a useful tool for the County and its partners to evaluate, stabilize, and divert individuals from inpatient stays as indicated. CSU's have been successfully utilized in many parts of the State to enhance crisis capacity and avoid unnecessary inpatient admissions.

A Crisis Respite site would not be eligible for the enhanced reimbursement available to a CSU, but would not require the dedicated medical staffing that drives the cost of a CSU.

### **Jail Based Mental Health Treatment**

The Sheriff has identified several areas of concern related to jail based behavioral health services. One of the most frequently identified gaps has been the inability to administer involuntary medications for psychiatrically impaired inmates. State regulation prohibits jails medical/mental health staff from administering involuntary medications for psychiatric symptoms outside of a designated facility. The SLO jail currently does not qualify for designation as a facility due to both staffing and physical plant concerns. With the changes in jail populations brought about by 2011 Public Safety Realignment/AB109, more inmates will spend longer sentences in jail, which increases the likelihood for psychiatric treatment while in custody. The following chart shows the number of services requested and provided to inmates while in custody, as well as the number of inmates referred for inpatient psychiatric restoration to sanity care. The Incompetent to Stand Trial, or "1370's" issue, will be discussed below.

San Luis Obispo County Behavioral Health  
Jail Counseling Program  
Monthly Statistics – 2015

| County code<br>40 | Total Contacts | On Meds | Un-Duplicated Inmates | Requests for Services | 1370 Admit to PHF | Quarter Undup Inmate Totals | Quarter 1370 Totals | New |
|-------------------|----------------|---------|-----------------------|-----------------------|-------------------|-----------------------------|---------------------|-----|
| January           | 595            | 426     | 679                   | 756                   | 2                 |                             |                     |     |
| February          | 578            | 279     | 478                   | 567                   | 2                 |                             |                     |     |
| March *           | 590            | 312     | 466                   | 657                   | 2                 | 1623                        | 6                   |     |
| April             | 652            | 401     | 622                   | 707                   | 3                 |                             |                     |     |
| May               | 583            | 454     | 631                   | 624                   | 1                 |                             |                     |     |
| June *            | 705            | 453     | 593                   | 651                   | 2                 | 1846                        | 6                   |     |
| July              | 600            | 412     | 650                   | 803                   | 3                 |                             |                     |     |
| August            | 573            | 404     | 639                   | 870                   | 1                 |                             |                     |     |
| September *       | 600            | 446     | 628                   | 692                   | 2                 | 1917                        | 8                   |     |
| October           | 690            | 418     | 575                   | 902                   | 3                 |                             |                     |     |
| November          | 584            | 443     | 557                   | 818                   | 5                 |                             |                     |     |
| December *        | 501            | 382     | 476                   | 472                   | 1                 | 1606                        | 9                   |     |
| January           | 472            | 351     | 492                   | 472                   | 1                 |                             |                     |     |
| February          | 530            | 224     | 471                   | 525                   | 3                 |                             |                     |     |
| March *           |                |         |                       |                       |                   |                             |                     |     |
| April             |                |         |                       |                       |                   |                             |                     |     |
| May               |                |         |                       |                       |                   |                             |                     |     |
| June *            |                |         |                       |                       |                   |                             |                     |     |
| Totals            | 3960           | 3080    | 4498                  | 5554                  | 19                | 3525                        | 15                  |     |

### **Drug and Alcohol Treatment in Jail**

Drug and Alcohol treatment The Community Corrections Partnership has funded a full time DAS specialist to provide substance use treatment in custody. The need for drug and alcohol treatment within the jail far surpasses the capacity of the current staff. The Department has submitted a budget augmentation request to increase services to jail inmates.

### **Restoration to Competency**

Penal Code 1370 describes the regulations and process for individuals found by the Court to be incompetent to stand trial (IST). Misdemeanant IST inmates are referred to the PHF for restoration to competency. Inmates charged with felony

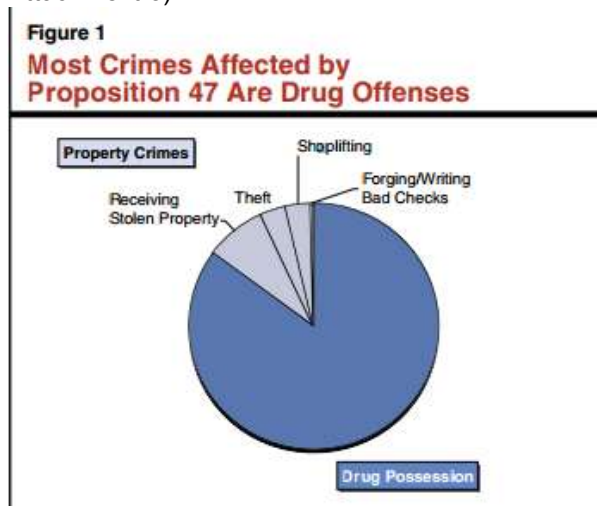
offenses who require restoration services are referred to State Hospitals, such as Atascadero State Hospital.

The PHF has a total licensed capacity of 16 beds. Census can vary widely from day to day. At times, the PHF has had to delay admission for IST inmates due to both capacity issues as well as patient mix. Fragile patients, especially seniors, may be put at risk if an inmate with poorly controlled behaviors is admitted. Special staffing, security, and interventions are required to ensure safety for all patients as well as staff. Any inmate while on the PHF requires one-on-one staffing. Other tools for managing violent behavior include the use of seclusion and restraint, involuntary fast acting medications (“medical restraint”), which are closely monitored and regulated to ensure that patients’ rights are not violated.

The Sheriff’s Department has collaborated closely with both jail mental health staff and the PHF to facilitate timely transfer for inmates who require restoration to competency, while assisting the PHF to manage capacity and population safety concerns. This will continue to be a joint effort, with plans to research and facilitate other options such as outpatient restoration services.

### **Other Gaps Associated with Law Enforcement and Public Safety**

Recent changes to sentencing through both AB109 and, more recently, Proposition 47, have shifted some of the treatment costs from the State Department of Corrections and Rehabilitation (CDCR) and the Department of State Hospitals (DSH) to counties. While Proposition 47 impacts are just beginning to be seen, potential future impacts include conversion of felony IST’s to misdemeanor charges, with subsequent release from State Hospitals to become the responsibility of the County. Impacts already being noted from Proposition 47 have caused the further reduction of felony drug court admissions with a large increase into the misdemeanor court process. Some individuals who are now charged with misdemeanors are choosing short jail stays rather than committing to treatment. (See LAO Report, Attachment 5)



Several committees including BHD, Sheriff, Police, Probation, Courts, DA, and public defender representatives are tracking both the impact and planning for the future of these challenges.

### **Sobering Centers**

A need to provide a safe place for community members, primarily but not exclusively homeless, to “detox” from substances, has been mentioned by many advocates both in the homeless community and law enforcement. “Sobering Centers” are one type of service that could be utilized as an alternative to booking individuals who are publically inebriated, or under the influence of drugs or alcohol, in jail. Community homeless service providers have also noted that a brief stay in a safe place with minimal supports, such as a Sobering Center, would reduce the risk of death or other serious outcomes to those individuals who are homeless and addicted. Sobering Center services have been proposed for several sites, however funding to support a sobering center, as well as neighborhood concerns, have presented barriers to its development. The Department, along with hospitals, the criminal justice system, homeless service providers and community members are researching funding streams and program types for this kind of facility.

### **“Detox”**

“Detox” has been discussed as a catchall phrase for treatment of addictions. There are several levels of detoxification services, from inpatient, to residential, to outpatient. Certain substances require or are supported by the use of

medications to provide a safe “detox” process or to manage cravings. Other substances, such as marijuana, do not require the use of medication assisted withdrawal or “detox”.

One of the most frequently requested levels of care in SLO has been for Residential Treatment. There are currently no licensed residential treatment facilities for drug and alcohol treatment in the County. The Department has utilized a combination of outpatient “detox”, or medication assisted withdrawal treatment, with Sober Living Environments (room and boards) to approximate a residential treatment level of care. However, providing a full range of licensed residential treatment in SLO would be optimal for treatment needs.

Under the expanded benefits for substance use disorder treatment through the Affordable Care Act, Licensed Residential Treatment is a Medi-Cal covered service. Very recently, Brian’s House, one of the Sober Living Environment providers, has begun the process to become a licensed residential treatment facility for Drug Medi-Cal services.

#### **Homeless Individuals Discharged from the PHF and other Institutions**

It has been noted that homeless individuals who are treated at the PHF are then released back to homelessness. Unfortunately, access to affordable housing is a barrier for many individuals, and especially for individuals who do not have sufficient funding or who have bad or non-existent rental and credit histories. Several new programs in the past 12 months have increased access to housing vouchers for the most vulnerable homeless. Those programs target medically fragile individuals, veterans, families of veterans, and CalWORKs recipients. However, there is still a paucity of immediately accessible housing for individuals being discharged from the PHF as well as from other facilities such as hospitals and the jail.

The Department has a MHSa funded Homeless Outreach Team (HOT), which often meets with patients while in the PHF to engage them in ongoing services and attempt to facilitate housing. Other providers of services to homeless community members are also working to develop additional transitional or “step-down” temporary housing for patients coming from either a psychiatric or medical institution.

#### **Assisted Outpatient Treatment (aka Laura’s Law)**

Assisted Outpatient Treatment programs authorized by “Laura’s Law” have been established in 8 out of 58 counties in California. While advocates point to studies of its effectiveness in other States, the experience in California has not yet provided extensive outcome information. Approximately 1 out of 20,000 individuals are estimated to be eligible for AOT services under the statutes as currently written.

Nevada County was the first county to establish AOT services, which they began in 2008. As of 2011, 37 individuals had been referred to the program. Of those, 22 agreed to participate in treatment without a court order, and eleven individuals have received a court order. Of the eleven, four did not accept treatment even though it was ordered.

Recently, the Mendocino County BOS approved a resolution to provide AOT services. The estimated cost of the service for four slots has been identified at \$100,000. The non-treatment costs for county counsel, public defender, and other court services are not included.

In 2014, the Department initiated discussions with representatives of the Sheriff’s Office and Superior Court about the possible implementation of an AOT program in our County. For many reasons, those discussions did not result in the generation of a proposal to establish a program. Future discussion related to funding, court services, and the challenges inherent in provision of AOT will continue with all partners. Additional information about AOT is provided in Attachments 6, 7 & 8 & 9.

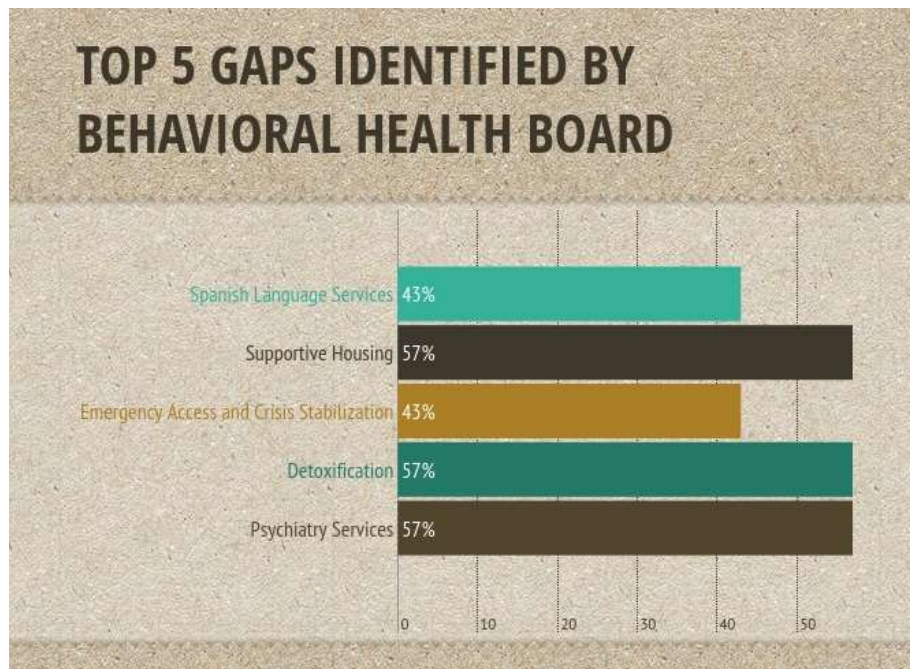
#### **Internal Assessment**

During 2014, Department leadership met on several occasions to study and analyze internal processes, challenges, gaps, and strengths. Strengths of integrity, dedication, hard work, values-driven, and persistence of staff were noted overall. Identified weaknesses were associated with poor communication, “siloes” funding and programs, and administrative delays.

Service gaps were identified both by leadership and staff through a survey completed in the Fall. Spanish language services, timely access to services, sufficient linkage and navigation, detoxification, and psychiatry services were most frequently identified as service gaps.



This survey was also responded to by members of the Behavioral Health Board. Their results closely mirrored the staff results:



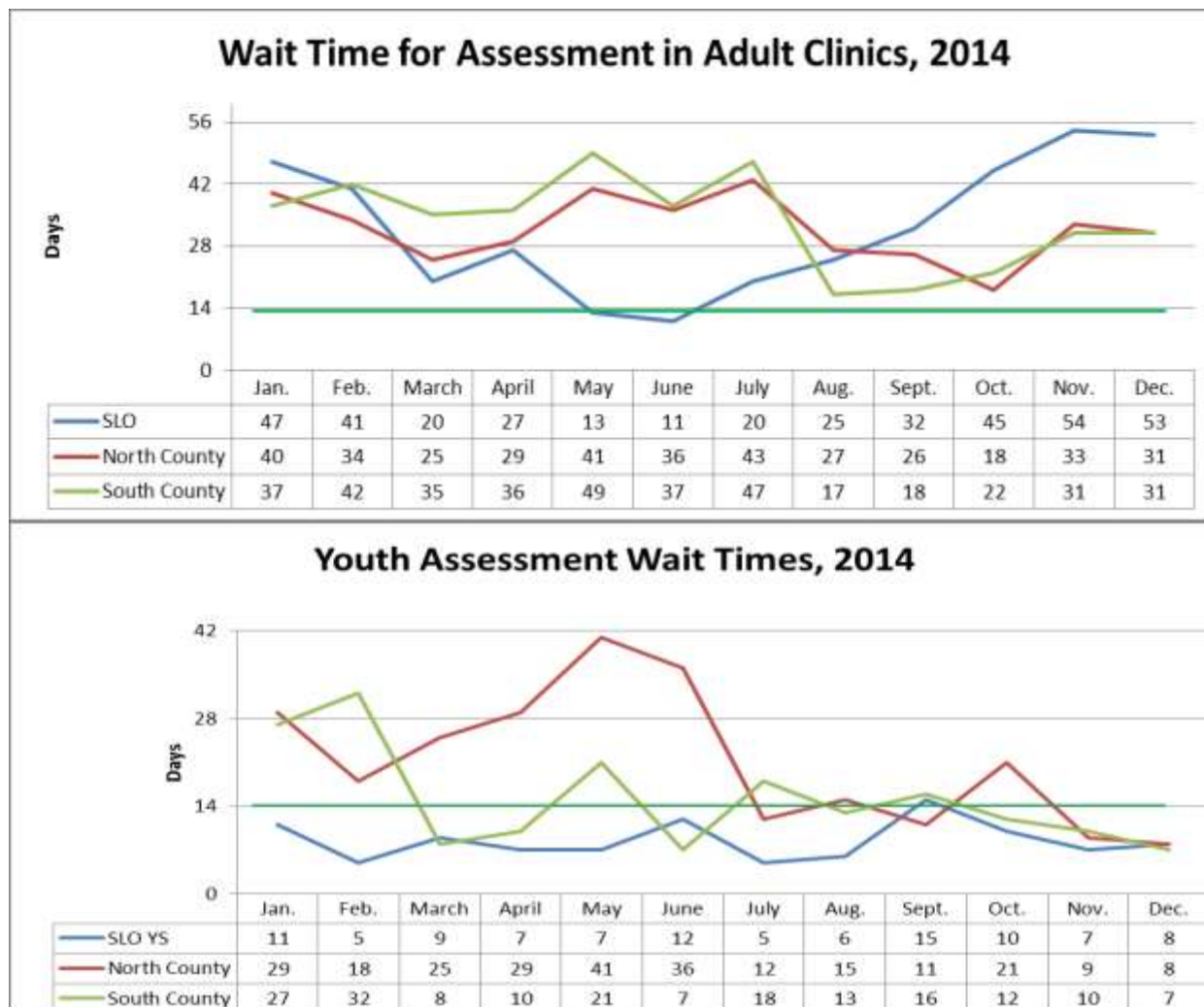
The full survey is included as Attachment 10.

The Department's Quality Support Team also collects data related to service levels, wait times, and utilization. Focused on mandated services within Mental Health, QST has repeatedly recognized the following areas of service gaps:

**Clinical Capacity Insufficient to Meet Mandated Service Levels**

As mentioned in the review of external stakeholder concerns, access to services is a primary area for improvement

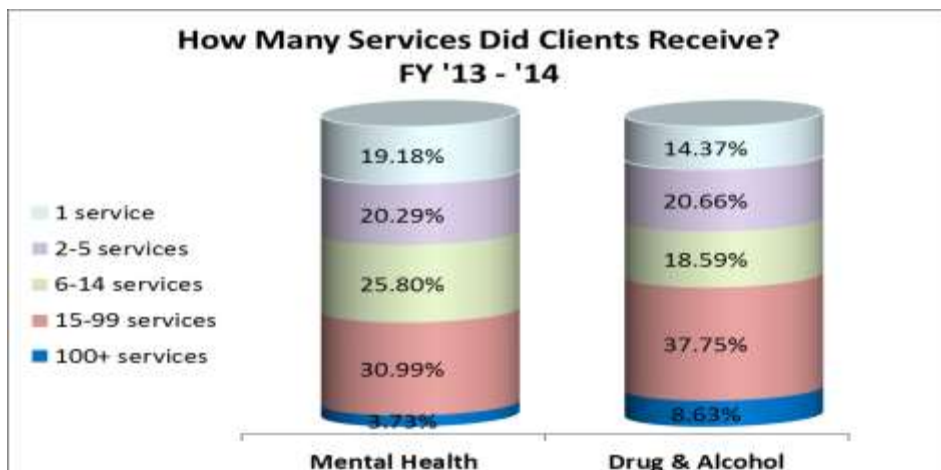
overall. The standard for access to “intake” (or assessment) for mental health services is 14 days from first request. The following charts indicate the challenges the Department has faced in meeting this standard.



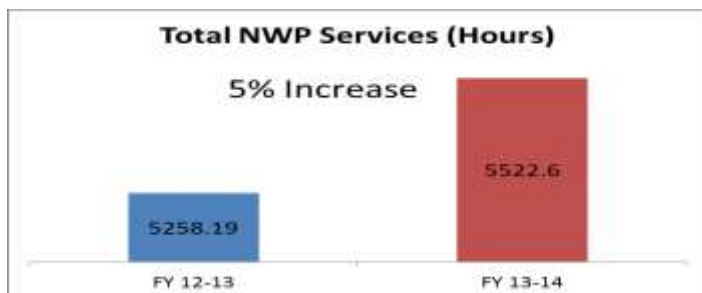
Mental health assessments lead to one of two possible outcomes. In the first, the client is determined not to meet “specialty mental health” criteria, and is referred to the appropriate provider, based on whether they have a mild to moderate level of impairment due to their mental illness or a non-psychiatric diagnosis. As was touched on earlier, the ACA expanded Medi-Cal benefits for treatment of mild to moderate levels of impairment. State DHCS has delegated the responsibility for ensuring the availability of care for those clients to CenCal Health, which manages that obligation through its contractor, the Holman Group. CenCal Health reports that in calendar 2014, over 1,800 clients were authorized for mild-to-moderate services, and those clients received almost 8,000 visits. This is a strong indication of the pent up need for mild to moderate mental health services within the County.

In the second possible outcome, individuals are assessed as meeting the “specialty mental health” criteria for treatment, and are therefore enrolled in the appropriate Department program and begin receiving services. The number of services a particular individual receives is based on several factors, including assessed level of acuity (how ill are they), type of services (individual or group psychotherapy, psychoeducation, medications, case management or other rehabilitative services), frequency of services (how often), and by which staff.

Assessments may lead to recognition of the need for, and referral to, drug and alcohol services as well as mental health treatment. Specialty or grant funded programs also have specific delineations of treatment, eligibility, frequency, and type of services.



One variant that has been noted as a gap in adult outpatient services for mental health is the lack of licensed clinicians as part of the treatment team. The Department has for many years contracted with private practitioners as network providers (NWP) for psychotherapy in office based settings. NWP services have increased by 5% from 2012/13 to 2013/14.



A standard of practice throughout the State includes licensed clinicians providing both clinical direction and psychotherapy within the treatment team, on site with the psychiatrists, medication managers, case managers, and other support staff. While some of the contracted NWP's do engage in collaborative care with the rest of the treatment team the model still presents barriers to the mandated menu of services with daily collaboration of all who provide services to eligible clients. By adding more licensed clinicians to the County treatment sites, the expected service enhancements will include better collaborative care, increased attention to level of care needs, and better compliance with the indicated treatment plan for the individual. The Department has submitted a budget augmentation request to increase clinical staff within the Adult outpatient services to accomplish this goal.

#### **Treatment Services in Spanish**

State Regulations require that treatment services be provided in other languages in situations in which over five percent (5%) of the population Spanish is considered a "threshold language" by the State (over 5% of the local population). Additionally, CenCal estimates that 30% (of Medi-Cal beneficiaries speak Spanish as either a primary or secondary language. BHD is measured by our External Quality Review Organization (EQRO) on the percentage of Medi-Cal eligible individuals in the County who receive mental health services within a certain racial/ethnic group. 14,370 individuals identified as Hispanic meet Medi-Cal eligibility criteria each month. 442 individuals identified as Hispanic are provided mental health treatment, for a rate of 3%. The Statewide average is 3.92%.

In 2014, the Mental Health division provided services to 196 clients who identified Spanish as their primary language. However, only 145 were able to be served by a bilingual provider (74%). The others were served through a combination of live and telephonic interpreters.

To better meet the needs of the growing Spanish speaking Medi-Cal eligible community, a focused effort to hire bi-lingual staff was begun in the last twelve months. Eight clinical staff speak Spanish at this time. Additionally, contracting for interpreter services is in process. A contracted "language line" is also available for telephonic interpretation.

### **Lack of Consistency in Psychiatrist Staffing**

The number of psychiatrists practicing in the State does not meet the increasing need of the populace for mental health services. SLO BHD has utilized "Locum Tenens" services to bring part-time, temporary psychiatrists to the county. Unfortunately, the temporary status of these providers contributes to delays in appointment times, more frequent changes in medication protocols, inability to develop a trusting, continuing relationship between the client and the provider, and inefficiencies as each provider needs to learn our Electronic Health Record (Anasazi) or be assisted by other staff which takes them from their current duties.

Despite the generous increase in pay approved by the BOS last year, while interviews for positions have increased, employment offers have not been accepted. The differential in pay between Counties and State organization (ASH, CMC) still presents an advantage for young, newly graduated doctors who have student loans and other obligations.

Recently, several of the contracted or temporary psychiatrists who have been working in the County have requested to become employees, and are in process. More interviews with psychiatrists from other areas have been scheduled. A "headhunter" organization will be contracted for focused recruitment. Telepsychiatry, which has been used for over a decade in many areas, will also be implemented after a competitive process for selection of provider agencies.

Midlevel practitioners, especially Nurse Practitioners, are also an excellent way to extend psychiatric services. The BHD currently employs 2 Nurse Practitioners and is in the process of contracting with an additional provider part time. Plans to engage the Nurse Practitioner training universities and become a field placement site are in process.

### **Increase "Productivity"**

Productivity is measured in many ways. For purposes of this report, emphasis will be placed on the need to recognize the existence of two important measures, and the need to balance the two. One measure of productivity is the number of clients seen per day. However, since the Department, like most health care delivery organizations, bills third party payers (Medi-Cal in our case), it is not productive to see so many clients per day that there is no time to generate the documentation necessary to bill Medi-Cal for the services, generating the very revenue sources that allows the Department to continue to provide the services. Therefore, a more useful measure of productivity is the percentage of time a clinician spends providing billable services, allowing for the time necessary to generate the documentation necessary to maximize the revenue associated with the delivery of those services.

Mental Health productivity is measured by documentation of services minute by minute. The time it takes to document the service is included in the overall billable time. Clients in mental health services receive a wide range of service type, from very intensive to basic. A staff member providing very intensive services may see only two or three clients in a day, whereas a clinic based staff person providing medication services may see 10 to 12 individuals in a day. The average expected productivity for a mental health staff member is 60%, or approximately 5 and one half hours a day of direct, documented services.

Clients in drug and alcohol services are seen in individual and group sessions. For Drug and Alcohol services, documentation time is not included in billable time, which is a fee for service model. On average, a drug and alcohol specialist will provide 2 to 3 group sessions in a day as well as individual appointments. Again, this will vary according to the specific intensity and purpose of the program. A daily total of 40% productivity is expected of Drug and Alcohol Services staff.

The Department's Electronic Health Record system (Anasazi) has presented a productivity challenge to both staff and administration. Typically, implementation of any electronic record reduces staff productivity up to 30% while the new system is being stabilized and staff becomes comfortable with its use. The Department has just completed rolling Anasazi out to all programs, including the PHF. Outpatient staff members who have now utilized the software for 2 years are becoming more proficient, and while many still have concerns that the software "slows them down", many individuals have developed good working habits to include documentation as part of their clinical service.

Productivity expectations of 60% for mental health staff and 40% for DAS staff are standard minimums throughout the State, with some Counties requiring higher percentages. Reports with data for supervisors and managers to assist their staff with measuring their productivity have been developed and are now being utilized in supervision discussions. Leadership is developing both additional staff resources for mentoring and support, and protocols for adherence to the standard expectation of productivity according to an individual's assignment.

Productivity has more implications than simple revenue generation. Productivity is also reflective of the appropriate use of time to see the correct number of clients in an efficient and effective manner. As the Department has seen increased requests for services, and as the mild to moderate level of care benefits have been made available through other providers, it is ever more essential to appropriately monitor the level of care and dosage (frequency of services as well as length of stay) for services provided.

### **Performance Metrics**

As the BHD's ability to collect data through Anasazi and other tools has improved, reports for performance measures have become both more available and more accurate. New clinical measures, the CANS (Child and Adolescent Needs and Strengths) and ANSA (Adult Needs and Strengths Assessment) will be implemented this year. These will allow staff to measure the progress of each client in mental health services to determine if the level of care and type of intervention being provided are appropriate and clinically effective. GAINSS and ASAM are two tools utilized to measure effectiveness and appropriateness of care in substance use disorder treatment. Through the CalOms DATAR, and GPRA data bases, performance outcomes for clients in DAS are tracked and reported to the State and Federal agencies. The County Behavioral Health Directors Association of California (CBHDA), recognizing that many State and other organizations frequently request information from Counties, is proposing a standardized set of performance outcome measures to allow for inter-county consistency of data elements and reporting. MOQA (Measures, Outcomes, Assessment, and Quality) domains will include data related to housing, criminal justice involvement, education and employment, timeliness and access to services, and administrative timeliness. The domain measures are still in draft form as they are being worked on by a statewide workgroup. (See Attachment 11)

Regular, standardized reporting of performance outcomes is a primary goal of the Department. The Health Agency has submitted a budget augmentation request for an additional software engineer to develop needed utilities to achieve this goal.

### **Looking Forward**

2014 was a year of many changes and challenges for the BHD. New leadership in both the Administrator and several Division Managers and program supervisors; the Affordable Care Act and changes to both eligibility and benefits; ongoing changes and adaptations in the Electronic Health Record; and regulatory changes at the State level presented multiple opportunities for adaptation and improvement by the department.

Over the next 2 to 3 years, California Behavioral Health will undergo further extensive changes. When California wants to make significant changes to its Medicaid program, it must take one of two steps: either (1) amend its State Medicaid Plan – the State's contract with the federal government; or (2) receive an exemption or Medicaid waiver from portions of Title XIX of the Social Security Act by the U.S. Department of Health and Human Services (DHHS). DHCS is in the process of amending the 1115b Medicaid Waiver for drug Medi-Cal services. Waivers allow States to amend or add to the federal Medicaid requirements for specific purposes. In the case of the proposed 1115b waiver, California is proposing that Counties be able to contract directly with providers through a selective process, rather than the current process which allows for any drug and alcohol services provider agency to apply directly to the State for drug Medi-Cal coverage. Other elements in the proposed waiver include expanded benefits, i.e. case management, to be covered by Medi-Cal. Medi-Cal waivers are programs under Medi-Cal that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under Medicaid rules.

The Mental Health Managed Health Plan is formed under a 1915b Waiver. This waiver is due for renewal by the end of 2015. Discussions have just begun to evaluate any proposed changes to this waiver.

Payment reforms are also important elements for the future of public behavioral health systems. There are several proposals to change from the current minute by minute billing process for mental health services and the underfunded fee for service methodology in the substance use disorder contracts. Capitation, Per User per Month (PUPM), Delivery System Reform Incentive Payment (DSRIP), are just a few of the proposed methods that are being researched for maximum effectiveness and efficiency to fund the varied, and growing, services for the behavioral health system.

The average life span of an adult with serious mental illness in the United States is approximately 53 years, or 25 years fewer than the average American. Integration of physical health care with behavioral health has frequently recognized as a best practice to reduce disparities in health care and increase health outcomes for individuals with serious mental

illness. The Department, with Transitions Mental Health (TMHA), the Center for Health Services of the Central Coast (CHC), Public Health, and local hospitals have joined in a Blue Shield Foundation grant funded project to study the current state of health integration and develop an improved system of collaborative or integrated care. B-HIP (Behavioral Health Integration Project) has collected and analyzed prevalence and use data for behavioral health services in the County. (Attachment 12). As a result of this project, plans to have a CHC physical health care provider come to Behavioral Health sites to provide primary health care service to individuals with serious mental illness, have been made. A SAMHSA grant to fund the implementation and initial operations of this project has been submitted. However, CHC and the Department have committed to bringing primary care to the Department sites with or without the additional grant funds.

The next several years will see continuing, perhaps vast, changes to the behavioral health care delivery system. The Department will energetically undertake the challenges and opportunities for change to improve both our delivery care system and the health outcomes of our community.

#### **OTHER AGENCY INVOLVEMENT/IMPACT**

Many organizations, both internal (County departments) and external, have shared their observations and perspectives on this topic with Agency and Department staff over the past year, and more, and those have all contributed to the content of this report.

#### **FINANCIAL CONSIDERATIONS**

There are no financial considerations associated with the Board's receiving this report.

#### **RESULTS**

This report is intended to help inform both the Board and other interested stakeholders about the nature of the County's behavioral health care delivery system. Being well informed will help the Board make effective policy decisions affecting the future of that complex system. Good decision making at the policy and management level of the organization helps achieve the Board's desired results of a safe, healthy and well governed community.

#### **ATTACHMENTS**

1. Attachment 1 rev – Target Population
2. Attachment 2 – SLO MHSA Programs
3. Attachment 3 – CA Mental Health Major Programs and Funding
4. Attachment 4 rev – Proposed Templeton Psychiatric Hospital
5. Attachment 5 – Prop 47 Impact
6. Attachment 6 rev – Assisted Outpatient Treatment
7. Attachment 7 – Position Statement on Involuntary Commitment
8. Attachment 8 – Civil Commitment
9. Attachment 9 – Report on AB1421 Planning Process
10. Attachment 10 – Employee Survey on Service Gaps
11. Attachment 11 rev – MOQA Reporting Guide DRAFT
12. Attachment 12 – Demand for Behavioral Health Services
13. Attachment 13 – CA Mental Health Funding